

Radiation Users Approval

Print or type all required information below

Name:	Work Phone:
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Employer:	Mail Code:
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Proposed Radiation Use:

Supervisor's Name:	Phone Number:
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RADIATION TRAINING

TRAINING	YES	NO	NO. OF HOURS	LOCATION
1. MSFC Radiation Training				
2. Principles And Practices Of Radiation Protection.				
3. Radioactivity Measurements Standardization And Monitoring Techniques And Instruments.				
4. Biological Effects Of Radiation.				
Have you had forty hours of radiation training?			Are you a M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	

EXPERIENCE

Check applicable area(s)

An "authorized user" on license no. _____ ☐ NRC ☐ State ☐ Certified in medical x-ray

☐ Administered isotopes to humans ☐ Used radiation monitoring equipment
☐ X-ray machine(s) ☐ Radioactive material ☐ College lab isotopes ☐ Multi-Curie sources
☐ Certified in radiography ☐ Radiation exposure limits ☐ Gas chromatography source(s)
☐ Other Explain: _____

Nuclide(s):	Amount Curie(s):	X-ray Equipment Output kvp:
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Purpose:

Location(s):

Duration:

SIGNATURES

Requester's Signature: _____ Date: _____

MSFC Radiation Safety Committee Action

Approved: ☐ Yes ☐ No

Signature: _____ Date: _____

Chairperson, MSFC Radiation Safety Committee

Special Conditions:

Attach additional information if necessary.